SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
PDD Waiver Notice of Termination of Services

Date Form is Completed: _____

Provider: _____

_____

RE: _____ _____
Recipient's Name Date of Birth

Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7 8 9 10

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____/_____/_____MAY BE BILLED.

For SC/EI: the effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, or admission to an ICF/MR or NF. This allows the consumer 10 days notice prior to termination of service.

- ☐ Service Coordination
- ☐ EIBI Services:
  - ☐ Annual Assessment
  - ☐ Plan implementation
  - ☐ EIBI Lead Therapy
  - ☐ EIBI Line Therapy
  - ☐ EIBI Self Directed Line Therapy

Reason:

- ☐ Change in need no longer justifies original request
- ☐ Change in/no longer meets ICF/MR Level of Care
- ☐ Change in provider availability
- ☐ Entered an ICF/MR
- ☐ Voluntary withdrawal
- ☐ Death (do not send a copy to the family)
- ☐ Condition has improved
- ☐ Consumer/legal guardian requested
- ☐ Medicaid ineligible
- ☐ Consumer moved out of state
- ☐ Other

Comments (required for all reasons):_____

_____

_____

Service Coordinator:_____

DSN Board/Provider:_____

Phone:_____

Address: _____

Signature: _____ Date: _____/_____/_____

Original: Provider **Copy**: Parent/Responsible Party, DDSN Cost Analysis, District Autism Staff, File, and Jasper DSN if appropriate

PDD Form 16-A June 6, 2008

APPEALS PROCESS IS ATTACHED